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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Good practices and major challenges in preventing and eliminating female genital mutilation

Report of the Office of the United Nations High Commissioner for Human Rights

Summary

The present report is submitted pursuant to Human Rights Council resolution 27/22 on intensifying global efforts and sharing good practices to effectively eliminate female genital mutilation. Following a brief overview of issues related to that practice and the applicable legal framework, the report contains a summary of some of the initiatives undertaken by States, United Nations entities and non-governmental and other organizations to eliminate it, and an analysis of the continued challenges. The report contains a number of conclusions and recommendations, as well as the observations that female genital mutilation in all its forms is prohibited under international human rights law and that States have an obligation to respect, protect and fulfil the right of women and girls to live free from female genital mutilation. The report includes a call on States to, inter alia, adopt and implement legislation that prohibits female genital mutilation, in accordance with international human rights law; develop comprehensive policies to address female genital mutilation, involving all levels of government; promote the education of girls; undertake education and awareness-raising initiatives; challenge the social norms supporting female genital mutilation and delink the practice from religion, social norms, harmful stereotypes and cultural beliefs that perpetuate discrimination against women; harness political leadership to end the practice; and harmonize data collection.

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I. Introduction

1. In its resolution 27/22, the Human Rights Council requested the United Nations High Commissioner for Human Rights to submit to it at its twenty-ninth session a compilation of good practices and major challenges in preventing and eliminating female genital mutilation.

2. The present compilation was prepared in consultation with States, United Nations entities, civil society organizations and other relevant stakeholders. All of the submissions for the report can be found on the website Office of the of the United Nations High Commissioner for Human Rights (OHCHR).[1]

II. Definition and legal framework

3. According to United Nations entities, female genital mutilation includes procedures involving the partial or total removal of the external female genitals or other injury to the female genital organs for non-therapeutic reasons.[2] According to the United Nations Children's Fund (UNICEF), in the 29 countries for which data was available, more than 130 million girls and women had been subjected to the practice. In half of those countries, the majority of procedures had been completed before the girls had reached the age of five. The practice can be found in some countries in Africa, the Middle East and Asia and in some communities in Latin America. It is also present in Europe, Australia and North America among communities originating from countries where female genital mutilation is practised.

4. The underlying reasons for the practice vary across cultures, between and within communities; however, under the cultural, religious and social surface, it becomes clear that they are all rooted in gender-based discrimination and harmful gender stereotypes about the role of women and girls in society. Female genital mutilation appears to be used as a means to control women's sexuality and is linked to other violations based on patriarchy and gendered norms, such as child and forced marriage, marital rape and intimate partner violence. In many communities, it is seen as an important rite of passage into womanhood and indicates a girl's readiness for marriage. Among female refugees and migrants and women with immigrant background, the practice can serve as marker of cultural identity and is often perceived as a source of personal and collective identity.

5. The practice often compromises the natural functions of girls' and women's bodies and has a profoundly detrimental impact on the health of women and girls, including their psychological and sexual and reproductive health. The short-term consequences of female genital mutilation can include death from hemorrhaging and severe pain, trauma and infections that may result from the procedure.3 Long-term consequences can include

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[1] www.ohchr.org/en/issues/women/wrgs/pages/eliminatefemalegenitalmutilations.aspx.

[2] World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, Economic Commission for Africa, United Nations Educational, Scientific and Cultural Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees, United Nations Children's Fund and United Nations Entity for Gender Equality and the Empowerment of Women, *Eliminating female genital mutilation: an interagency statement* (Geneva, 2008).

Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequence can include recurrent bladder and urinary tract infections, cysts,

chronic pain, infections, decreased sexual enjoyment and psychological consequences, such as post-traumatic stress disorder. The practice is also associated with increased risks of birth by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, low birth weight in infants and inpatient perinatal death.[4]

6. The Committee on the Elimination of Discrimination against Women, the Human Rights Committee, the Committee on the Rights of the Child and the Committee on Economic, Social and Cultural Rights have identified female genital mutilation as practices that directly affect women's and girls' abilities to enjoy their human rights on an equal footing with men, and which therefore violate their rights to non-discrimination and equality. Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the rights of the Child 18 (CEDAW/C/GC/31-CRC/C/GC/18) identifies female genital mutilation as a harmful practice and notes that the harm that these practices cause to the victims often has the purpose or effect of impairing the recognition, enjoyment and exercise of the human rights and fundamental freedoms of women and children.

7. The joint general recommendation/general comment also notes that, overall, harmful practices are often associated with serious forms of violence or are themselves a form of violence against women and children. States have a due diligence obligation to prevent, investigate and punish acts of violence against women, whether those acts are perpetrated by the State or occur in private.[5]

8. In her report (E/CN.4/2002/83), the Special Rapporteur on violence against women, its causes and consequences described female genital mutilation as the result of the patriarchal power structures that legitimize the need to control women's lives, arising from the stereotypical perception of women as the principal guardians of sexual morality, but with uncontrolled sexual urges. Both the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child have underlined that harmful practices such as female genital mutilation are deeply rooted in societal attitudes that regard women and girls as inferior to men and boys and expressed concerns about the use of these practices to justify gender-based violence as a form of "protection" or control of women and children. In this regard, States are required, under article 5 of the Convention on the Elimination of All Forms of Discrimination against Women, to take all appropriate

infertility, an increased risk of childbirth complications and new-born deaths, and the need for later surgeries. See WHO fact sheet No. 241, on female genital mutilation, available from www.who.int/mediacentre/factsheets/fs241/en/.

[4] J. Abdulcadir, M.L. Rodriguez and L. Say, "Research gaps in the care of women with female genital mutilation: an analysis", *BJOG: an International Journal of Obstetrics and Gynaecology*, vol. 122, issue 3 (February 2015).

[5] The Human Rights Committee, in its general comment No. 31 (CCPR/C/21/Rev.1/Add. 13), obligates States to protect individuals from acts committed by private persons or entities. In its general recommendation No. 19 (see HRI/GEN.1/Rev.6), the Committee on the Elimination of Discrimination against Women sets out the responsibilities of States to exercise due diligence, not only in preventing violations, but also in investigating and punishing such acts. Article 19 of the Convention on the Rights of the Child requires States parties to protect children from physical, sexual and mental violence through legislation and other social and educational measures. That obligation includes protection from acts perpetrated by parents or other caregivers. Article 2 of the Declaration on the Elimination of Violence against Women (General Assembly resolution 48/104) explicitly defines female genital mutilation as a form of violence against women and calls upon States to protect women against any form of violence that occurs within the family, household or in other environments. The Declaration urges States to condemn violence against women and to refrain from invoking tradition or religion to evade their obligations under international human rights law.

measures to modify social and cultural patterns of conduct, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

9. The above-mentioned joint general recommendation/general comment also notes that sex and gender-based discrimination intersect with other factors that affect women and girls, in particular those who belong to or are perceived as belonging to disadvantaged groups and who are therefore at a higher risk of becoming victims of harmful practices.

10. Human rights mechanisms have indicated that female genital mutilation may amount to torture and cruel, inhuman or degrading treatment or punishment, as set forth in articles 1 and 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[4] and violates the right to life when it results in death.

11. The practice also violates the right to health.[5] The Committee on the Elimination of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee have all expressed concern about the medicalization[6] of female genital mutilation and have urged States not to limit criminalization of the practice only to those who perform the practice outside of hospitals and without medical qualifications. The Committee on the Elimination of Discrimination against Women has raised concerns about the conflation and description of the practice as female circumcision. There are fundamental differences both in the harmful effect, intent, purpose and consequences associated with female genital mutilation and "circumcision" performed on boys and men. For example, female genital mutilation is often used to primarily control women's and girls' sexual desires, while male circumcision does not have this intent or result.

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[4] In its general comment 2 (CAT/C/GC/2), the Committee against Torture explained that States have an obligations regarding the prohibition of torture and other ill-treatment to address the activities, such as female genital mutilation, of private persons or entities. The Committee noted that female genital mutilation violates the physical integrity and human dignity of women and girls and has called on Governments to enact legislation prohibiting the practice, to punish perpetrators and to adopt necessary measures to eradicate it (see, for example, CAT/C/CR/31/6, CAT/C/KEN/CO/1, CAT/C/TGO/CO/1, CAT/C/TCD/CO/1and CAT/C/MRT/CO/1). In his 2008 report (A/HRC/7/3), the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment recognized that, like torture, female genital mutilation involved the deliberate infliction of severe pain and suffering, and considered that it constituted a violation falling within his mandate.

[5] According to article 24, paragraph 3, of the Convention on the Rights of the Child, States are obliged to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

[6] Medicalization refers to any act of female genital mutilation that is condoned by a State and performed in both public and private hospitals by trained medical personnel. This includes the performance of excisions by health workers and the use of modern medication to relieve pain and fight infection. Trained health professionals who perform female genital mutilation violate the human rights of women and girls. They also violate the fundamental medical ethic to do no harm. See WHO and others, *Eliminating female genital mutilation: an interagency statement*. In his 2008 report (A/HRC/7/3), the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment made it clear that, even if a law authorizes the practice, any act of female genital mutilation would amount to torture and the existence of the law by itself would constitute consent or acquiescence by the State. Also, in cases where acts of female genital mutilation are performed in private clinics and the physicians who carry out the procedure are not prosecuted, the State de facto consents to the practice and is therefore accountable. Art. 5 (b) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) prohibits, through legislative measures backed by sanctions, all forms of female genital mutilation, scarification, medicalization and para-medicalization of female genital mutilation and all other practices, in order to eradicate them.

III. Good practices to eliminate female genital mutilation

A. Legislative measures

12. At the time of writing, more than 40 countries have enacted legislation against female genital mutilation. In Mauritania, ordinance 2005-2015 prohibits medical practitioners and government health facilities from carrying out the procedure. Egypt and Kenya prohibit parents and guardians from pressurizing their children to undergo the practice. Ugandan and Kenyan laws on female genital mutilation make its performance and the discrimination against a woman who has not undergone the practice a crime. In Nigeria, while there is no federal law prohibiting the practice, states can enact specific legislation prohibiting the practice, as several already have.

13. Research by the Demographic and Health Surveys Programme (http://dhsprogram.com) indicates significant reductions in prevalence where States have enacted and enforced comprehensive criminal sanctions against female genital mutilation. In Kenya, where the prevalence rate has fallen from more than 50 per cent of girls in 1980 to 20 per cent in 2010, 71 cases related to the practice have gone to court and 16 of these cases have resulted in convictions. Burkina Faso has witnessed a reduction in the practice among young women and has recorded at least seven convictions for practising or abetting female genital mutilation. In 2014, two public mobile tribunal hearings in two separate provinces involving the mutilation of 14 girls resulted in six-month sentences for the perpetrators. Eritrea has convicted and fined at least 155 female genital mutilation practitioners, as well as parents of girls who underwent the practice, while Ethiopia has undertaken 13 prosecutions and, in Guinea-Bissau, at least 14 cases have gone to court and one perpetrator has been sentenced since 2012. In Uganda, following the adoption of the Female Genital Mutilations Act in 2010, 15 cases were brought before courts and, in November 2014, five people were convicted for performing the practice. Since 1983, when it introduced a special act prohibiting female genital mutilation, France has jailed about 100 persons for involvement in the practice. French police claims that the number of mutilations has decreased as a result of the trials and other prevention initiatives.[9] On 26 January 2015, in the first case since the adoption of a 2008 law against female genital mutilation, a court in Egypt convicted a medical doctor following the death of a 13-year-old girl after he had performed the practice on her in a private clinic.

14. Cross-border female genital mutilation is increasingly documented, partly owing to the criminalization of the practice and to strict enforcement of legislation prohibiting it in countries with large practicing communities. In accordance with article 44, paragraph 3, of the Council of Europe Convention on preventing and combating violence against women and domestic violence, States parties must ensure that the practice is punishable if committed in a third country by or against one of their nationals or residents, even if the practice is not considered a criminal offence in that country. Similarly, States parties must take the measures necessary to establish jurisdiction over a female genital mutilation offence when an alleged perpetrator is present on their territory. This principle of extraterritoriality has been introduced into many European laws. Sections 1 and 4 of the Female Genital Mutilation Act (2003) of the United Kingdom of Great Britain and Northern Ireland make it a criminal offence for any person, regardless of their nationality or residence status, to carry out or be involved in carrying out female genital mutilation. In 2006, Italy introduced a specific criminal law provision on the practice (Law No. 7/2006),

[9] European Institute for Gender Equality, *Good practices in combating female genital mutilation* (Luxembourg, 2013).

making it punishable even if it is committed outside the country. Denmark, Norway, Spain, Sweden and Switzerland have criminalized practicing or assisting or abetting the practice of female genital mutilation, both inside and outside the countries. In 2011, Kenya added an extraterritoriality clause in its law, making performing female genital mutilation outside its border a criminal offence for Kenyans. In 2012, Ireland adopted the Criminal Justice (Female Genital Mutilation) Act, which prohibits the practice of or attempts to practice female genital mutilation.

15. In addition to enforcing legislation and policies on female genital mutilation, some countries have also established mechanisms to monitor progress in elimination efforts and have allocated resources for implementation, including equipping relevant officials with the requisite personnel, financial, technical and other resources. For instance, Kenya's law prohibiting the practice mandates the establishment of an anti-female genital mutilation board, which has both an operational and advisory role, including for securing adequate resources for combatting female genital mutilations.

16. Enforcement of national legislation should include special considerations for victim and witness confidentiality and the provision of services, including protection for parents and girls who reject the practice. As the perpetrators of female genital mutilation tend to be family members, victims are often unwilling to support prosecution, and in some instances may refuse to provide police investigations with a statement. Family pressure to accept the practice can be immense; there are documented cases of threats to parents who have refused that their daughters undergo the practice and also of girls who claimed to have mutilated themselves in order to protect their parents. A number of countries have addressed witness and victim protection needs in their legislation on the practice. For instance, United Kingdom legislation grants automatic anonymity to victims of the practice who report the incident to the police.

B. Comprehensive action plans

17. In addition to legislation, the elimination of female genital mutilation requires complex multisectoral strategies involving all sectors of government and the wider public, including the media, civil society groups, community leaders, medical professionals and teachers. It also requires addressing and engaging with beliefs and social attitudes and norms within the communities where it is practised.

18. The following States have implemented comprehensive and coordinated action plans against female genital mutilation:

- Burkina Faso's action plan establishes an intersectoral group comprising 13 ministries, as well as women's groups, religious and community leaders, law enforcement officials and the judiciary, to oversee the implementation of its law on the practice
- In 2013, the Ethiopian Ministry of Women, Children and Youth Affairs launched a two-year national strategy on harmful traditional practices that involves the health and social care sectors; in addition, the Government, with the assistance of United Nations agencies and non-governmental organizations, has designed child protection networks
- Senegal's national action plan for the period 2010–2015 involves the creation of regional committees, departmental and rural communities for the abandonment of female genital mutilation; as a result of this multi-dimensional approach, thousands of villages in Senegal have reportedly publicly abandoned the practice and other harmful practices

- Cameroon's national action plan, in partnership with civil society such as the Council of Imams and Muslim Dignitaries of Cameroon includes support for the socioeconomic reconversion of practitioners.

- Egypt, Cameroon, the Gambia, Guinea, Guinea-Bissau, Mali and the United Republic of Tanzania have developed multisectoral strategic action plans that involve different government institutions and emphasize awareness-raising, while, in 2004, Mauritania adopted a five-year national action plan against gender-based violence and the Government has pledged to adopt in 2015 a law against gender-based violence, including female genital mutilation.

C. Education and awareness-raising

19. According to the United Nations Population Fund (UNFPA) and UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change,[10] comprehensive formal, non-formal and informal education linked with awareness-raising programmes can contribute greatly to preventing female genital mutilation.

20. Evidence shows that the incidence of harmful practices such as female genital mutilation decreases with gains in female literacy. A survey by UNICEF in Egypt found that 72 per cent of women with no education wanted the practice to continue compared with 44 per cent of women with higher levels of education. Furthermore, 15 per cent of women with no education wanted to abandon the practice, compared with 47 per cent of women with higher education.[11] In another survey conducted by the organization Human Rights Watch in Yemen, mothers who had no education or only primary school education were more likely to subject their daughters to the practice, and mothers with more children were more likely to have at least one daughter undergo the practice.[12]

21. A number of civil society organizations provide scholarships for girls to enable them to remain in school as a means of preventing female genital mutilation. In the United Republic of Tanzania, for instance, the Maasai Women Development Organization has given scholarships to enable girls who otherwise would have been mutilated and forced into marriage to remain in school.[13] The Pastoralist Child Foundation is working in Samburu and Maasai Mara, Kenya, to eliminate the practice through educational sponsorships for girls.[14] In 2014, the county of Pokot in Kenya committed to spending over $1 million on eliminating female genital mutilation, with much of the funding to be used to provide scholarships for girls.[15]

22. Information and awareness-raising on the harmful impact of female genital mutilation and its legal prohibition are critical to eliminating the practice. The abovementioned UNFPA-UNICEF Joint Programme supports community-based educational dialogues in 17 countries. The dialogues are often led by a community health worker and involve sharing information on human rights, health and gender norms. Under the programme, workshops on the harmful impact of the practice were held in Mauritania

[10] Available from www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-accelerating-change.

[11] http://www.unicef.org/egypt/Eng_FGMC.pdf, accessed on 17 February 2015.

[12] Human Rights Watch submission.

[13] See www.unwomen.org/en/news/stories/2012/11/escaping-the-scourge-of-female-genital-mutilation-in-tanzania-a-maasai-girls-school-provides-schol#sthash.oo0jgOpB2.dpuf.

[14] See www.indiegogo.com/projects/girls-education-community-education-in-samburu-and-maasai-mara-kenya.

[15] Equality Now submission.

and assistance provided for the development of a road map to strengthen the ability of the Ministry of Endowment of Yemen to encourage public leaders, including religious leaders, to oppose it.

23. The organization Equality Now offers support to the Government of Kenya to translate the Prohibition of Female Genital Mutilation Act into a language that can be understood by the public, and is supporting its translation into Kiswahili to expand its reach among the populations in areas where the practice is prevalent. It has also issued 1,000 copies of the Act to Kenyan primary school head teachers to encourage teachers to play a role in ending the practice.

24. Examples of programmes that work with young people, including on outreach programmes in schools and the wider community, were highlighted. For instance, Senegal has introduced "Tostan", a participatory education programme that works at the village level to incorporate literacy and essential health education, including information about female genital mutilation, into the learning experiences of the entire community. Senegal has also incorporated prevention of the practice into elementary and junior high schools curricula. In Burkina Faso, the National Committee has piloted training for teachers and incorporated female genital mutilation into the natural sciences curriculum within schools.

25. In 2014, a youth summit in the Gambia brought together 100 Gambians aged 17–25 years to build their campaigning and social media skills and equip them with the legal and medical knowledge to raise awareness on the practice among young people. In Djibouti, the UNFPA-UNICEF Joint Programme assisted in mobilizing 500 young people to become engaged in the global campaign to end female genital mutilation and 30 young girls were trained to become youth peer educators for the abandonment of the practice in their respective communities.

26. The Ministry of Health of Egypt and the national council for childhood and motherhood hold regular workshops on female genital mutilation and open days in youth centres across the country to raise awareness on the harmful impact of the practice. In eastern Ethiopia, the Office of the United Nations High Commissioner for Refugees (UNHCR) in partnership with a community-based non-governmental organization, the Mother and Child Development Organization, conducted awareness-raising campaigns and weekly group discussions, referred to as "coffee ceremonies", and mobilized youth clubs against the practice in three Somali refugee camps.

27. From 1998 to 2006, the female genital mutilation prevalence rate in the Niger was halved as a result of the work of civil society groups, in particular the Nigerien committee on traditional practices, which carried out studies, awareness-raising interventions, training, advocacy and retraining for practitioners, to stimulate behavioural change in concerned communities. It also assisted in setting up monitoring committees to track activities in remote villages.

28. In Mauritania, the UNFPA-UNICEF Joint Programme collaborated with the National Theatre and organized a sensitization tour on female genital mutilation in five high-prevalence regions of the country. A large number of other sensitization activities were also carried out in collaboration with partner non-governmental organizations. Following the tours, 76,850 people made public declarations against the practice.

D. Engaging religious and community leaders

29. In Ethiopia, the Ethiopian Orthodox Church, the Evangelical Church and the Ethiopian Islamic Supreme Council officially and formally stressed that female genital mutilation is not a religious requirement, and originates in practices that precede religion. They also pledged to integrate relevant messages into their religious teachings.

30. In 2013, the OHCHR office in Guinea Bissau supported and provided technical assistance to the national non-governmental organization Djinopi in the organization of an Islamic conference on combating female genital mutilation, involving Islamic professors from Egypt, Mali and Senegal. The conference resulted in a declaration on the abandonment of the practice by the imams of Guinea Bissau. To reinforce the outcome of the conference and the declaration, Djinopi published a "golden booklet" with short Islamic statements against female genital mutilation, which has been disseminated to neighbouring countries and countries with high prevalence rates.

31. In Mauritania, dialogues with religious leaders have led to the development of a model sermon and a collection of arguments against female genital mutilation based on religious documents, which was launched in February 2013 and distributed to 500 imams.

E. Other initiatives to address societal attitudes and support for female genital mutilation

32. In 2008, the Government of Colombia, with technical assistance from the International Organization for Migration and UNFPA, initiated a project called "Embera Weta" aimed at changing discriminatory social and cultural patterns of violence against women. The project resulted in a public rejection by Emberá women and community leaders of female genital mutilation as harmful to women and having no basis in culture. The project has enabled women, both in Emberá and among other indigenous communities, to be agents of change.

33. The involvement of older women who may themselves have undergone female genital mutilation in programmes to eliminate the practice has proved successful. German development cooperation has created intergenerational dialogues designed to empower target groups to change behaviour. The dialogues have been used in several countries.

34. In Mali, the "child-to-child and "child-to-parents" approach adopted by the organization Plan International has allowed girls to promote their rights with their parents and communities, through acting, drawing, poetry and songs. The "child-to-child" approach recognizes children as effective agents of change, since they communicate more effectively than adults, are often more literate than their parents and look after younger siblings. This has helped many girls to express themselves in public and share their experiences without fear and embarrassment.[14]

35. As fathers, brothers, husbands, community and religious leaders and politicians, men hold many of the decision-making roles that allow the practice to continue and can play a role in ending female genital mutilation and other harmful practices. Challenging dominant norms of masculinity is an important step towards ensuring that men and boys are strong advocates for tackling the practice and for changing attitudes and behaviours in communities and society at large. In Egypt, Plan International has used an innovative non-formal education programme called "New Visions" that encourages the development of life skills and increases gender sensitivity and reproductive health knowledge among groups of boys and young men aged 12–20. The same concept has been used for girls through a similar programme called "New Horizons", to increase self-confidence and demystify and communicate essential information on basic life skills and reproductive health. These groups have helped to break the silence, promote attitudinal and behavioural changes among men and women, as well as reduce the social pressure that gives rise to the practice.

[14] See http://plan-international.org/about-plan/resources/blogs/fighting-fgm-progress-hidden-behind-numbers-in-reports.

Plan International has found that community dialogue and discussion is crucial for greater ownership of the project by the community.[17]

36. UNHCR has established an advocacy group called "Men against female genital mutilation" comprising 300 men in the Dadaab refugee camp in Kenya. The group members undertake peer education activities, acts as role models and work in close cooperation with the police and other agencies.

37. In the Sudan, and later in Somalia and Egypt, the "Saleema" initiative promoted the association of positive values with women who have not undergone female genital mutilation. Saleema is an Arabic word that means, inter alia, "unharmed". One of the key objectives of the initiative was to model and popularize the use of the world Saleema itself as a positive terminology for describing women and girls who have not undergone the practice. In 2014 alone, over 340 communities in the Sudan participated in community dialogue activities as part of the Saleema initiative, and approximately 95 communities organized public declarations for the abolishment of the practice using the initiative "Saleema Al Taga".

F. Political leadership

38. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children has identified political will as "the centre of achieving zero tolerance to female genital mutilation." Evidence shows that statements by politicians condemning female genital mutilation are essential to challenging support for the practice and that, in many countries, they have led to greater engagement of religious, tribal and community leaders against it, as well as an increase in human and financial resources allocated for this purpose.[18] Throughout 2014 Guinea-Bissau saw strong statements of support for the abandonment of the practice by political parties, the Government and influential leaders. In addition, the country has appointed a national ambassador for the abandonment of female genital mutilation, and has mobilized key national musicians and media figures to participate in cultural events to advocate for its abandonment. Senegal's national action plan provides for an active role for parliamentarians, in particular female parliamentarians, in terms of speaking out against the practice in their constituencies and working with religious leaders.

G. Promoting alternative rites of passage

39. Women who undergo female genital mutilation have reported feelings of empowerment and social acceptance and those who have refused report feelings of exclusion, shame, stigmatization and loss of honour and social position.[19] Alternative rites of passage are important to address these feelings and perceptions.

40. In Kenya, the UNFPA-UNICEF Joint Programme supported alternative rites of passage among practicing communities, who viewed the new practice as culturally acceptable and marking a girl's entry into adulthood. The alternative rites of passage involved community participatory education on local culture, life skills, communication

[17] Plan International submission. See http://plan-international.org/where-we-work/africa/egypt/what-we-do/reduction-of-harmful-traditional-practices-htp

[18] United Nations Population Fund (UNFPA), "Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation" (New York, 2014). Available from www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf.

[19] Human Rights Watch submission.

skills, self-awareness, family relationships, sexuality, coping with adolescence, sexually transmitted infections, HIV/AIDS and gender-based violence. The Young Women's Christian Association of Kenya implements an alternative rites of passage seminar for girls at risk. Teachers and parents identify girls, who are taught a series of modules based on a training manual covering sexual and reproductive health education, female genital mutilation awareness, myths around the practice, legal implications and children's rights and protection from it.

41. In the United Republic of Tanzania, OHCHR supported a UNFPA-led special event where over 1,000 children chose an alternative rite of passage over mutilation. The alternative rite of passage involved a one-month training course on human rights, reproductive health and the culture of their local community, which concluded with a graduation ceremony. Similar alternative rites of passage activities have been conducted in the Gambia.

H. Cross-border, regional and international cooperation initiatives

42. Efforts at the regional and international levels aim at promoting awareness and information-sharing on female genital mutilation. Countries of origin and migrant communities in destination countries are increasingly forming partnerships and engaging in coordinated approaches to prevent the practice.

43. Togo is currently developing cross-border programmes to combat female genital mutilation with neighbouring countries. Similarly, since 2011, Burkina Faso and Mali have collaborated in a joint project on preventing its cross-border practise.

I. Protection and support services

44. Girls and women who have undergone female genital mutilation need quality health care and psychosocial and sexual care. Eritrea, Mauritania, Kenya, Burkina Faso, Ethiopia, Mali, Somalia and Uganda have all strengthened the capacity of health personnel to address the practice and its consequences. In Ethiopia, health workers are operating outside the clinical setting and offering support to schools, women's groups and faith networks.

45. In Finland, the National Institute of Health and Welfare raises awareness and provides information on female genital mutilation in maternity and child health clinics, hospitals and health centres; and schools and student health centres. In September 2014, University College Hospital in London opened its first specialist clinic for child victims of female genital mutilation, offering medical treatment and psychological help to girls up to 18 years of age who have suffered or may be at risk of the practice. Somalia has integrated female genital mutilation-related issues in its midwifery training curriculum in its South Central, Puntland and Somaliland regions, including in antenatal care, neonatal care and immunization services. Similarly, Burkina Faso has integrated the practice into reproductive health programmes and set up a specialist clinic to address the complications of female genital mutilation.

46. The World Health Organization is updating clinical guidelines for health providers to support evidence-based care. In Ethiopia, the Addis Ababa Fistula Hospital is dedicated exclusively to providing free obstetric fistula repair surgery to women, and a community called Desda Mender is dedicated to the lifelong support of women whose fistulae are irreparable.[28] Specialized clinics for victims of female genital mutilation have also been

[28] Project Hannah Africa submission.

opened in Germany. In Switzerland, the University Hospital of Geneva operates specialized consultations led by female doctors on female genital mutilation. The programme offers various services, including a personalized prevention information review and deinfibulation for cases of type III female genital mutilation.

47. In addition to health services, several civil society organizations are engaged in providing protection services to girls at risk. In Kenya, the Tasaru Ntomonok Initiative provides shelter for girls trying to escape female genital mutilation, including with a view to ensuring they remain in school and supporting their integration into their communities.[71] Burkina Faso has established a free child line for the public to report suspected cases and for survivors or other affected parties to receive counselling. In Ethiopia, child protection networks provide support to girls who have been mutilated and have established links between child protection officers, the police, schools, community groups and faith organizations to share information to identify proactively those girls at risk of the practice.

J. Addressing female genital mutilation in minority communities

48. Specific issues may arise in addressing female genital mutilation when it is practised only by minority communities, such as refugee women and women migrants. Measures to address the practice in this context have focused on legislation, strengthening the capacity of the relevant professionals to effectively address the practice through training and guidelines, as well as awareness-raising among targeted communities.

49. In addition to information campaigns, a growing number of countries have developed action plans that contain practical guidance on targeted interventions, including on how front-line professionals can challenge the social norms that drive the practice, as well as how individuals and communities can themselves contribute to changing the social norms that underpin the practice. Finland's action plan on the prevention of female genital mutilation for the period 2012–2014 requires local authorities to provide sufficient training on the practice for employees and to carry out self-monitoring.

50. Since 2000, Norway has implemented four successive action plans to prevent and combat female genital mutilation. The current action plan for the period 2013–2016 against forced marriage, female genital mutilation and severe restrictions on young people's freedom contains 22 measures, including on the roles of schools and the foreign service missions, the need for safe housing and improved cooperation and expertise in the public sector.

51. Similarly, in Portugal, the Government has implemented two action plans involving actors from several sectors and with different expertise, so as to address the different perspectives on female genital mutilation, including health, reproductive and sexual rights, justice, immigration, gender equality, development cooperation and education. Members of the group come from public administration bodies, international organizations and non-governmental organizations. The Government produced various materials on the practice for health-care professionals, patients and police officers, as well as a post-graduate course on female genital mutilation for health-care professionals who intend to work in high prevalence areas and who are expected to act as focal points in their community's health centres and hospitals upon graduation. Under the action plan, Portugal has created a biannual award, entitled "Against female genital mutilation – change the future, now", which offers immigrant associations support to develop awareness and prevention projects

[71] Equality Now submission.

about the practice in the communities at risk, especially those associations that are very effective in their communities but do not have access to national or European Union funds.

52. In an attempt to reach out to affected communities, the Danish Ministry of Children, Gender Equality, Integration and Social Affairs has developed a mobile application on how to tackle "honour-related" conflicts, including in relation to female genital mutilation. The application targets ethnic minority young people, as well as professionals, informing them that the practice is illegal, and that persons conducting or contributing to it (also outside of Denmark) risk prison sentences.

53. In March 2014, the United Kingdom adopted a national action plan based on a multi-agency approach to providing support and care services for women and girls living with female genital mutilation or for women and girls at risk of the practice. It also established a female genital mutilation unit to coordinate cross-government policy, to collect and disseminate best practices and to provide outreach support on the practice. It published multi-agency guidelines on female genital mutilation to support and assist front-line professionals, such as teachers, health professionals, police officers and social workers. In April 2014, it became mandatory for any health-care professional to collate and submit basic anonymized details about the number of patients treated who have undergone the practice.

54. The Government of Spain has created a national strategy to eradicate violence against women for the period 2013–2016, which describes female genital mutilation as a form of violence against women, and has developed a protocol on medical action against the practice.

55. In 2011, the Government of the Netherlands developed an official document to help parents withstand pressure from their families. The document, entitled "Statement opposing female circumcision", outlines the health consequences of female genital mutilation and relevant Dutch legislation. It has been translated into several languages and is handed out to parents who attend children's health-care centres and also to school doctors.

56. In March 2013, partner organizations of the European End Female Genital Mutilation campaign – including the Mediterranean Institute of Gender Studies, the Family Planning Association of Portugal, the Italian Association for Women in Development and AkiDwa of Ireland – launched an e-learning tool, offering information and practical advice on female genital mutilation in Europe. The campaign's e-learning course aims to raise awareness and enhance the skills of health professionals and asylum officers and social welfare officers. The training is supported and endorsed by UNHCR and is available in English, Portuguese and Italian.

57. A number of countries, including Germany, Japan, Norway, Sweden and the United Kingdom, have implemented cross-country programmes to address female genital mutilation. In 2010, the European Parliament launched a campaign against the practice, and in 2014 the Council of Europe, with Amnesty International, produced a guide for member States on how to design policies and measures to better address the practice, based on the Council of Europe Convention on preventing and combating violence against women and domestic violence.

IV. Challenges in addressing female genital mutilation

58. Submissions received reveal a number of constraints and challenges that States face in their efforts to meet their obligations to respect, protect and fulfil the rights of women and children to live free from female genital mutilation.

59. Legislation in most countries provides for large fines and prison sentences for those who engage in the practice. However, effective enforcement is often inadequate, particularly in States with plural legal systems and even more so where customary, traditional or religious norms may appear to support female genital mutilation. Furthermore, prosecutions remain rare. This is partly due to the nature of the practice, which poses particular investigation challenges to law enforcement officials. The ceremony is often deeply taboo, usually performed in the privacy of the family or community and shrouded in secrecy. It is also not immediately obvious that a woman or a girl has been subjected to female genital mutilation, and law enforcement officials often lack accessibility to rural areas where it is carried out. In a number of places, the enforcement of laws against female genital mutilation and the punitive legal approach has driven the practice underground.

60. There is also a gap in the protection afforded by existing legal frameworks. Most States have criminalized female genital mutilation when it takes place on national territory or when a girl is taken abroad for mutilation if she is a citizen or permanent resident of the State. This fails to recognize the obligation of States to protect all children within their jurisdiction and does not take into consideration the mobile, transnational character of practicing communities. A further challenge is insufficient collaboration among Governments across borders. Girls living near border areas are most vulnerable, particularly if they are living next to countries with weaker legislation against the practice than their own.

61. There is evidence that the medicalization of female genital mutilation has risen. However, reliable data on medicalization is difficult to obtain. Allowing medical professionals to perform the practice is often the logical response of parents who are under social pressure to have their daughter undergo female genital mutilation, but who want to minimize harm. Medicalization can also act as an additional source of income for health-care workers and can undermine efforts to eliminate the practice.[22]

62. United Nations and regional human rights mechanisms have raised concerns with regard to genital surgeries on intersex infants and children for non-medical reasons.[23] The Committee on the Rights of the Child has called upon States to ensure that no one is subjected to unnecessary medical or surgical treatment during infancy or childhood, to guarantee bodily integrity, autonomy and self-determination to children concerned and to provide families with intersex children with adequate counselling and support.[24]

63. The collection of reliable data on female genital mutilation in countries where minority communities perform the practice remains a major challenge, as do the lack of capacity of relevant officials and the absence of standard guidelines. Many front-line professionals, such as teachers, medical professionals and child protection officers, are not trained in or may not understand the law, or may be unfamiliar with the issue and fail to record cases. Similarly, while there is empirical evidence showing that female genital mutilation can result in deaths, many Governments do not collect or maintain official data on deaths associated with the practice, and hospitals do not have policies of recording female genital mutilation-related deaths.

[22] Plan International, "Tradition and rights: female genital cutting in West Africa", 2005. Available from www.plan-uk.org/resources/documents/27624.

[23] See, inter alia, CRC/C/CHE/CO/2-4, CAT/C/DEU/CO/5, A/HRC/22/53 and A/64/272. See also the statement by the Council of Europe Commissioner for Human Rights, available from http://on-usa.org/1720/council-of-europes-statement-on-intersex-peoples-need-for-equal-rights.

[24] See CRC/C/OPSC/CHE/CO/1.

64. Despite the commitment of Governments to address the practice, in many instances support in the form of shelters and other services for victims and girls at risk are inadequate. Very few countries make provisions in law or policy to offer protection following allegations of female genital mutilation. The practice does not fit easily into systems to prevent violence against women or child protection systems. For instance, in several European countries, agencies that typically report on suspected child abuse cases do not report female genital mutilation as they are often unaware of its occurrence. Furthermore, most domestic violence shelters do not accommodate children, constraining many girls to take refuge in schools or in the home of community leaders, at times with limited access to food or sanitation and exposure to further risks.

65. In the area of service provision, a key challenge is the lack of evidence on effective interventions and strategies to mitigate the health consequences of female genital mutilation. This includes a need to improve the knowledge base about obstetrical and gynaecological consequences.[14]

66. The persistence of social norms that perpetuate female genital mutilation, differences in the underlying reasons for the practice and cultural environments where it takes place make it particularly challenging to eliminate the practice. However, the positive results of programmes to prevent female genital mutilation demonstrate that attitudes in support of the practice can be successfully addressed.

V. Conclusions and recommendations

67. **States have the obligation to respect, protect and fulfil the right of women and girls to live free from female genital mutilation. Good practices in a number of countries should be supported, increased in scale and replicated. They include:**

(a) The establishment of comprehensive policies, such as action plans, involving all relevant ministries and other stakeholders, including religious and community leaders, teachers, health providers and the media;

(b) The adoption and implementation of legislation that prohibits female genital mutilation, in accordance with international human rights laws;

(c) Comprehensive education and awareness-raising programmes targeting women and men at all levels of society, including religious and community leaders, on the harm and root causes of female genital mutilation and responses;

(d) Campaigns to change societal norms that drive the practice, and the creation of an enabling and supportive environment for the human rights of women;

(e) Campaigns that delink the practice from religion, and the debunking of social norms, harmful stereotypes and cultural beliefs that perpetuate discrimination on the basis of sex, gender, age and other intersecting factors;

(f) The incorporation of guidelines on female genital mutilation into medical education and training curricula;

[14] WHO has identified four thematic areas where research is needed to improve clinical management on the basis of significant gaps in the evidence and controversy regarding optimal management: (a) obstetric outcome and post-partum perineal re-education; (b) defibulation outside of pregnancy or labour; (c) clitoral reconstruction; and (d) training, skills and confidence of health care providers. See I. Abdulcadir, M.I. Rodriguez and I. Say, "Research gaps" (see para. 5, footnote 4).

(g) Measures to ensure girls' access to high-quality education, including comprehensive sexuality education;

(h) Accessible protection mechanisms and services to safeguard girls at risk, including services such as emergency help lines, health care, legal services, counselling and shelter for girls who run away in order to avoid female genital mutilation;

(i) Adequate social and medical services for women and girls and women who are living with female genital mutilation.

68. States should strengthen efforts to share experiences and good practices, including concerning data-collection tools, methodologies and expertise. Furthermore, States should take the necessary measures to ensure the coherent and consistent harmonization of all relevant legislation and to ensure its primacy over customary, traditional or religious law.

69. States should incorporate evidence-based training on female genital mutilation into medical, midwifery and nursing curricula so as to improve the diagnosis and management of the practice and to prevent its medicalization.

70. States should allocate sufficient resources to civil society groups and other partners so as to effectively carry out programmes at the community level to eliminate the practice. This should include the creation of safe spaces in schools and communities where girls and young women can gather and discuss the issues that affect them.

71. States should ensure that adequate safeguards are in place to prevent cross-border female genital mutilation. States should also make it a criminal offense to perform of or be involved in carrying out the practice abroad, regardless of the nationality or residence status of the perpetrator and even where the victim is not a national or does not have permanent or similar habitual residence of the country, in accordance with the Convention on the Right of the Child.

72. Political leadership is crucial to address female genital mutilation. Political, religious and community leaders play an important role in speaking out against the practice.